

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-012864

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 102

FILED APR 4 1963

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Charles		Length of stay in 1b 2 hrs.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		d. STREET ADDRESS (If outside, give location) Flint Hill	
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Helen J. Iffrig			4. DATE OF DEATH Month Day Year Mar. 22, 1963		
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-8-1878	9. AGE (last birthday) 85	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (City and state or country) St. Peters, Mo.	12. CITIZEN OF WHAT COUNTRY USA	

13a. FATHER'S NAME Aloys Iffrig		13b. MOTHER'S MAIDEN NAME Helen Schwendemann		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. B		17. INFORMANT A.B. Iffrig Sr. St. Peters, Mo.	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. Arteriosclerotic Cardiovascular Dis. DUE TO (b) 5 yrs DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 hrs
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION St. Peters, Mo.	COUNTY St. Peters, Mo.	STATE Mo.
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21. I attended the deceased from Oct. 1958 to March 22, 1963 and last saw her alive on March 22, 1963 Death occurred at 6:20 P. m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE R.M. Keller (Degree or title) M.D.	22b. ADDRESS Wentzville, Mo.	22c. DATE SIGNED 3-23-63
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 3-25-63	23c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery	23d. LOCATION (City, town, or county) St. Peters, Mo.	(State)
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24. FUNERAL DIRECTOR Geo. Stiefvater St. Peters, Mo.	25. DATE RECD. BY LOCAL REG. 3-25-63	26. REGISTRAR'S SIGNATURE Marcella Wilson
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(Licensed Embalmer's Statement on Reverse Side)

3/25/63

USE BLACK INK

OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

VS 300
Rev. 4/59

DATE AMENDED

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APR 10 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Jerry A. Davis

Licensed Embalmer No. 5139

P. O. Address Fallon, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.